

**Authorization for the Disclosure of Information
 DHHS Division of Children and Family Services
 Economic Assistance**

Client Name (Last, First, M.I.)	Date of Birth
Client Address	Social Security Number
Information will be disclosed to: (Name, Address, City, State, Zip)	
The information to be released pursuant to this authorization is limited to records/information from or in the possession of the Nebraska Department of Health and Human Services (DHHS), Division of Children and Family Services, Economic Assistance.	

Specific DHHS Division of Children and Family Services, Economic Assistance Information to be disclosed (Check all that apply):

- ☐ Entire Medical Record, including, but not limited to, patient histories, memoranda, notes (except psychotherapy notes), test results (except raw data and items from psychological test protocols), films, records, diagnosis, evaluations, examinations, discharge summaries, aftercare information, billing records, insurance records, records sent by other health care providers, and medications.
- ☐ All information regarding alcohol/drug treatment, mental health information, and HIV-related information.
- ☐ All information regarding Economic Assistance being provided by DHHS to the client.
- ☐ Other (please specify):

This Authorization shall terminate on the following date or event: _____, or 60 days after the date of signing this release, if no other date or event is indicated.

By signing this authorization, I acknowledge that the information to be released may include material that is protected by federal or state law and may relate to Drug/Alcohol treatment, mental health, and HIV-related information. I understand I may revoke this authorization at any time by submitting a written revocation to DHHS. I understand that DHHS cannot control what the recipient does with the released information and that such information might be redisclosed by a third party, and that the released information might no longer be protected by federal or state law.

I understand that failure to sign this form will not affect treatment, payment, enrollment in a health plan, or eligibility for benefits except in limited circumstances. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me.

Client's Signature _____ Client's Printed Name _____ Date _____

Client Representative Signature* _____ Client Representative Printed Name _____ Date _____

*Please specify Client Representative Type: ☐ Parent, ☐ Guardian, ☐ Attorney in Fact [Power of Attorney]

NOTICE TO RECIPIENT

This information disclosed to you is protected by state and federal laws (to include Federal Regulations, 42 CFR Part 2 of 1983) which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.